Claimant is requesting:	
Medical	☐
Mental Health Counseling	☐
Loss of Wages	☐
Funeral/Burial	☐

State of Arizona
Arizona Criminal Justice Commission
Crime Victims Compensation Program
Application

Date Received:_____
Reviewed By:_____

CVC Claim No. _____

✓ **Please complete the application as thoroughly as possible and SIGN the application on page 5.**

PART 1: VICTIM INFORMATION

Victim's Last Name		First Name	Middle Name
Address (Street)			Sex: ☐ Male ☐ Female
City	State	County	Zip Code
Date of Birth		Home Phone ( )	Work Phone ( )
Social Security Number (Optional)			Is victim deceased? ☐ Yes ☐ No

PART 2: CLAIMANT INFORMATION *(Complete ONLY if different from victim)*

Claimant's Last Name		First Name	Middle Name
Address (Street)			Sex: ☐ Male ☐ Female
City	State	County	Zip Code
Date of Birth		Home Phone ( )	Work Phone ( )
Social Security Number (Optional)			
Your Relationship to the Victim			

Please List The Following Information For Each Victim/Derivative Victim *(Attach additional sheets if necessary)*

Victim/Derivative's Name	Social Security Number (Optional)	Date Of Birth	Relationship To Victim
1.			
2.			
3.			
4.			

PART 3: CRIME INFORMATION

Type of Crime (*check one*)

- ☐ Assault
- ☐ Homicide
- ☐ Sexual Assault/Adults Only
- ☐ Child Abuse (Physical & Sexual)
- ☐ DWI/DUI
- ☐ Stalking
- ☐ Robbery
- ☐ Terrorism
- ☐ Kidnapping
- ☐ Other Crimes (List)_____

Was this crime DOMESTIC VIOLENCE related?

☐ Yes ☐ No

Date of Crime	Date Crime Reported	Law Enforcement Agency Reported To

Name of Officer/Detective	Report Number
Location of Crime	**Offender(s) Name**

Briefly Describe Crime and Injuries (Attach additional sheets if necessary)

PART 4: CIVIL LAWSUIT INFORMATION

Have you or will you file a civil lawsuit (sue) in relation to this crime? ☐ Yes ☐ No ☐ Undecided

If yes, please list the name and address of your attorney:

Attorney's Name	Phone Number ( )

Street Address	City	State	Zip Code

PART 5: BENEFIT INFORMATION

Since the crime have you received or are you entitled to receive any of the following benefits listed below. For each benefit checked, please supply requested information on Lines 1 through Line 4 below. (Attach additional sheets if necessary)

AHCCCS	☐	Health/Accident Insurance	☐	Social Security (SSD)/(SSI)	☐
Auto Insurance	☐	Indian Health Services	☐	Tribal Assistance	☐
Tricare/Military	☐	Life Insurance	☐	Veteran's Benefits	☐
Child Protective Service	☐	Medical Insurance	☐	Vision Insurance	☐
Dental Insurance	☐	Medicare/Medicaid	☐	Workers Compensation	☐
Disability Insurance	☐	Restitution (from offender)	☐	Other:_____	
Employee Assistance	☐	Sick Leave/Vacation	☐		

Are any of these benefits pending (*please specify*) _____

For each benefit checked, please supply requested information on Lines 1 through Line 4 below. *(Attach additional sheets if necessary)*

Type Of Benefit	Address	Phone ( )	Agency / Policy Number
1.			
2.			
3.			
4.			

PART 6: TYPE OF COMPENSATION REQUESTED

A. MEDICAL

Are you seeking payment for medical, hospital, or traditional healing expenses that are crime related? ☐ Yes ☐ No

Name Of Provider	Address	Account Number	Phone	Date Of Service
1.			( )	
2.			( )	
3.			( )	
4.			( )	
5.			( )	
6.			( )	

B. MENTAL HEALTH COUNSELING:

Are you seeking payment for mental health treatment expenses that are crime related? ☐ Yes ☐ No

If **YES,** are you currently seeing a provider? ☐ Yes ☐ No

If **YES,** are you claiming mileage for crime related mental health counseling?

Name Of Provider	Address	Account Number	Phone	Date of Service
1.			( )	
2.			( )	
3.			( )	

MILEAGE: Are you claiming mileage for crime related medical or mental health counseling? ☐ Yes ☐ No

If **YES**, please list the dates of trips and the mileage traveled round trip:

Date of trip_____ Mileage traveled round trip_____

Date of trip_____ Mileage traveled round trip_____

Date of trip_____ Mileage traveled round trip_____

Date of trip_____ Mileage traveled round trip_____

C. WORK/SUPPORT LOSS: (All sick leave and vacation leave available must be utilized first – wage loss is calculated at the minimum wage rate)

Are you seeking work loss benefits as a result of the injury or mental distress? ☐ Yes ☐ No

If **YES,** please answer the questions listed below:

Date first unable to work as a result of injury or mental distress:_____

Date returned to work:_____

Total time lost from work_____

Hourly rate of pay_____ Number of hours worked per week_____ Hours worked per day_____

Place of Employment Supervisor's Name

Address City State Zip Code Phone

( )

REQUIREMENT: A signed statement on office letterhead stationery from the employer will be required to verify the above work loss information. A signed statement on office letterhead stationery from the doctor or mental health therapist is also required stating that the victim was unable to work as a result of crime related injuries, the length of time the victim was unable to work and the date the victim was able to (or will be able to) return to work.

D. FUNERAL EXPENSES:

Are you seeking payment for crime related funeral expenses? ☐ Yes ☐ No

Name of Funeral Service Provider:	Amount $
Address City State Zip Code	Phone ( )

REQUIREMENT: If you answered YES to Part 6A, 6B, 6C, or 6D, please attach a copy of ALL bills, contracts, receipts and insurance statements received to date.

PART 7: STATISTICAL INFORMATION (Optional)

The following information is used for statistical purposes only. It is needed to comply with federal regulations. Information Applies to the VICTIM only.

Ethnic Group: ☐ Caucasian ☐ Hispanic ☐ Unknown
☐ African American ☐ Native American/Eskimo ☐ Other_____
☐ Asian/Pacific Islander

Arizona Resident: ☐ Yes ☐ No Federal Crime: ☐ Yes ☐ No
Handicapped: ☐ Yes ☐ No

I learned about the Crime Victim Compensation Program from:

☐ Victim Assistance Program ☐ Prosecutor ☐ Medical Service Provider ☐ Self Referral
☐ Law Enforcement Agency ☐ Brochures/ Posters, etc. ☐ Social Service Agency ☐ Other

RETURN COMPLETED APPLICATION TO:

MARICOPA COUNTY ATTORNEY'S OFFICE
VICTIM COMPENSATION BUREAU
301 WEST JEFFERSON, 9TH FLOOR
PHOENIX, AZ 85003

If you have any questions,
please contact our office at (602) 506-4955.

Fax #: (602) 506-6527

You Must Sign In Three (3) Places Or Your Application Can Not Be Processed.

Carefully read and sign the declarations below. Your application will not be processed unless this form is completed and signed on each of the three signature lines.

Declaration

I hereby certify, subject to the penalty of fine or imprisonment, that the information contained in this application for a crime victim compensation award is true and correct to the best of my knowledge.

Certification of Eligibility

I certify that all of the information provided on this form by me and/or others is true and accurate to the best of my knowledge and belief.

I certify that I am not currently serving a sentence of imprisonment in any detention facility, and had not escaped from serving a sentence of imprisonment in any detention facility, home arrest program or work furlough at the time of the criminally injurious conduct.

I certify that I will fully cooperate with all appropriate law enforcement, prosecutorial and criminal justice agencies and provide the information requested understanding that if I do not cooperate any and all benefits may be denied.

_____ _____ X_____

Date **Please Print Name** **Signature of Claimant/Applicant**

Arizona Criminal Justice Commission
Subrogation Agreement

Agreement made this_____ day of _____, 20_____, between the Claimant, _____ and the State of Arizona by the Arizona
(Claimant's Name)
Criminal Justice Commission Crime Victim Compensation Program of Maricopa County.

In consideration of monies to be paid to me or paid to others for my benefit in accordance with the Crime Victim Compensation Program Rules as an award through the Crime Victim Compensation Program, I, _____, hereby assign, transfer and subrogate to the State of Arizona the first right to the full extent of any monies paid as stated above, and also to the Maricopa County Crime Victim Compensation Program to the extent that the monies advanced were obtained from sources other than the Arizona Criminal Justice Commission, all rights which I may have to receive, or recover any benefits or advantages which I may have against any party who may be liable for claim, loss, damage, or injuries suffered for which an award was made.

_____ _____ X_____

Date **Please Print Name** **Signature of Claimant/Applicant**

Authorization to Release Confidential Information

I authorize the release of medical, dental, and psychotherapy records to the Crime Victim Compensation Program for the purpose of verifying my claim and my eligibility for Crime Victim Compensation. I authorize and request any person or agency having information, including any law enforcement records, which are necessary to the administration of my claim to release that information to the Maricopa County Crime Victim Compensation Program. This release includes, but is not limited to, private and government physicians and hospitals; local, state, and federal law enforcement and prosecutors offices; local, state, and federal court personnel; any employer, any private company or governmental agency which is providing, or may provide, medical or monetary benefits. I agree and certify that no person or agency shall incur any legal liability to me by releasing any information pursuant to this authorization.

I authorize my attorney to provide any information for this purpose of verifying my claim and eligibility for crime victim compensation and to provide information concerning any potential recovery which I may have against any person or entity arising from the criminally injurious conduct. I understand that the records obtained by the Maricopa County Crime Victim Compensation Program may be subject to release in accordance with Arizona and federal law.

_____ _____ X_____

Date **Please Print Name** **Signature of Claimant/Applicant**